How to make FY1 Psychiatry posts work in the community

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The Problems

• Some early FY1 posts were converted CT posts
• Clinical supervisors’ expectations?
• Reputation in acute trusts (not necessarily $\psi$)
  – F1 trails around after a nurse
  – Don’t see senior doctors
  – House jobs are about learning medicine & surgery
  – Resentment at loss of workforce in acute trusts
• Teething probs – Psychiatrists not FP aware
What we have in SW London

Tolworth Hospital
F1 in **Kingston North CMHT**
Since Aug 2014

St George’s Hospital
F1 in **Perinatal Psychiatry team**
Since Aug 2013

Jubilee Health Centre
F1 in **Cheam CMHT**
Since Aug 2009

Springfield Hospital
F1 in **Merton Home Treatment team**
Since Aug 2013
Outpatient clinics

Perinatal psychiatry

- F1 in clinic adjacent to consultant
- Sees new patients initially for 1hr, presents to consultant (& later does all the write-up).
- Immediately afterwards consultant reviews patient with F1 Dr
- F1 has small caseload of follow-up patients
  - These pts are seen intermittently by consultant
  - Patients pleased as get more time with F1
Outpatient clinics

Cheam CMHT

• F1 sits in clinic with consultant for new assessments
• The consultant simultaneously enters assessment into electronic record system during the F1 interview; Consultant will step in when needed
• For most patients, F1 will do part of the assessment and will use as mini-CEX
• F1 will also work closely with the assessment team, assisting with triage; and the Recovery Support team, assisting with physical health screening for difficult to engage SMI patients
Home/community visits

Merton Home Treatment team

• F1 always visits with an experienced clinician
• Developmental aspect of post
  – F1 takes more responsibility with experience
• Daily team MDT meeting
• Lots of consultant contact
• Higher Specialist trainee (SpR) in team
Responsibility & expectations

- HTT clinician holds responsibility for decisions
- HTT reminded that F1 not experienced
- F1 will advise on physical health questions
- All F1s do de-escalation & breakaway training
- When consultant on leave, cross cover from inpatient consultant
- Good feedback from F1s
One day each week in acute trust

• All F1 Psychiatry posts have 1 day/week back in acute trust
  – With exception of Perinatal/Liaison (acute trust)
• Working in acute medical unit
• Now working well, some teething probs
• Important for F1s to
  – Maintain links with peer group
  – Keep up core physical health skills
Trainee Feedback

• Did you feel your community psychiatry placement contributed to your overall development as a doctor?
  – All answered positively

• Did you feel your placement balanced learning opportunities with service provision?
  – 2 trainees answered positively, 1 neutral

• Did you feel that you had to perform tasks outside your competency?
  – 1 trainee answered “monthly”, 2 “one of a one off occasion only”
Trainee Feedback

• Positive Trainee Comments
  – “Excellent experience conducting full psychiatric assessments everyday”
  – “Community team were very supportive. Enjoyed the ethos behind psychiatry, and the chance to work in a team. Non-hierrarchical, felt my opinion was listened to”

• Negative Trainee Comments
  – “Safety considerations occasionally with home visits. Large amounts of time travelling between patients”
Trainee Feedback – Inpatient / Liaison Placements

• This compares favourably with feedback from other Foundation trainees in Mental Health trust (14)
  – 71% of these gave generally favourable feedback
  – 60% felt their placement balanced service provision with learning opportunities well
Summary

• F1s are not core trainees
• Start with expectation of “med student plus”
• Planning appropriate supervision is key
• One day/week in acute trust very important
• As year progresses, training: service ratio reduces
• F1s have been some of our most enthusiastic and rewarding trainees
• F1 important for recruitment into Psychiatry
EXTRA SLIDES
Addtl notes for Cheam CMHT

After the first week, the F1 is expected to **lead** on aspects of the assessment - history and mental state exam; the consultant leads on discussions around points of clarification and care plan / formulation etc, although toward the end of the placement they will often take the lead on discussions around care planning. The consultant will type notes whilst the F1 interviews the patient (this fosters a team approach, and makes better use of the resources tied up with the assessment / clinical supervision process) - the F1 is responsible for all the data entry and the letter to the patient and the GP, which will be co-signed by the consultant. This process both increases the consultant's capacity to assess patient's (by reducing the amount of administration that the consultant would otherwise have to do following the assessment) and dramatically improves the skills and confidence of F1 doctors in assessment and formulation (they are under constant scrutiny!)

I have tried the ‘perinatal’ approach - e.g. allowing them to interview the patient on their own before presenting and then jointly seeing the patient: This can work well, but I am always left with an uncertainty about their formulation, and then end up doing my own mini assessment to reassure myself that they are not missing something risky, or unusual. This also has an impact on patient experience (they are at the clinic longer than they would've been if they had seen me directly); and on a practical note, we really struggle for space at the Jubilee health centre!

They will also follow up on selected patients.

Regards, Stuart